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No. 91-2079

In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

vs.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED JUNE 26, 1992
CERTIORARI GRANTED OCTOBER 13, 1992

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CHRONOLOGICAL LIST OF RELEVANT
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GOOD SAMARITAN HOSPITAL, ET AL. v. BOWEN,

Case No. CV 88-L-523 (D. NEB.)

Sept. 21, 1988—Complaint with attachments filed in U.S. District Court for the District of Nebraska.

Nov. 15, 1988—Amended complaint with attachments.

Dec. 22, 1988—Answer to amended complaint.

Feb. 16, 1990—Memorandum and Order on Plaintiffs' motion for summary judgment and Defendant's motion for summary judgment.

Feb. 16, 1990—Judgment for Plaintiffs on certain issues and for Defendant on certain issues. Case remanded to Secretary.

Apr. 13, 1990—Notice of appeal by Plaintiffs.

Apr. 16, 1990—Notice of appeal by Defendant.

CHRONOLOGICAL LIST OF RELEVANT
EIGHTH CIRCUIT DOCKET ENTRIES FOR
GOOD SAMARITAN HOSPITAL, ET AL. v. SULLIVAN,

Case Nos. 90-1641NE and 90-1642NE

Dec. 30, 1991—Opinion. Judgment of the District Court is affirmed in part and reversed in part.

Jan. 13, 1992—Appellants' petition for rehearing with suggestion for rehearing en banc.

Feb. 7, 1992—Order. The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA
LINCOLN DIVISION

Civil Action No. 88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D., SECRETARY OF
HEALTH AND HUMAN SERVICES, DEFENDANT.

[FILED NOV. 16, 1988]

AMENDED COMPLAINT FOR DECLARATORY RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

Plaintiffs, for their causes of action, allege as follows:

PARTIES

1. Plaintiffs (hereinafter "providers" or "hospitals") are licensed as general acute care hospitals by the State of Nebraska and are certified as "providers" of hospital health services under Title XVIII of the Social Security Act, as amended, Health Insurance for the Aged and Disabled. 42 U.S.C. §§ 1395 *et seq.*

2. Defendant Otis R. Bowen, M.D., (hereinafter "Secretary") is the Secretary of Health and Human Services, and as such is responsible for the administration of the Department of Health and Human Services (HHS or

Department), including the Medicare Program. The Health Care Financing Administration (HCFA) is the operating component of HHS charged with administration of the Medicare program.

JURISDICTION AND VENUE

3. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (1974 and Supp. 1982); the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983); the Administrative Procedure Act, 5 U.S.C. §§ 553 and 706; the Declaratory Judgment Act, 28 U.S.C. § 2201; the Fifth Amendment to the United States Constitution; and 28 U.S.C. § 1361.

4. Jurisdiction is grounded in 42 U.S.C. § 1395oo(f)(1).

5. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f) (1).

THE MEDICARE STATUTORY AND REGULATORY FRAMEWORK

6. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as "Medicare". 42 U.S.C. §§ 1395-1395ccc.

7. To participate in the Medicare program, a hospital must file a "provider agreement" with the Secretary of Health and Human Services, pursuant to 42 U.S.C. § 1395cc. A provider receives reimbursement from Medicare for services to Medicare beneficiaries. For a provider's fiscal years beginning before October 1, 1983, reimbursement was based upon the "reasonable cost" of such services. 42 U.S.C. § 1395f(b) (1) (A). "Reasonable cost" is defined as the "cost actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v) (1) (A).

8. In 1972 Congress amended § 1395x(v) (1) (A) of the Social Security Act to authorize the Secretary to establish limits on costs reimbursable under Medicare, based upon estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the Medicare program. 42 U.S.C. § 1395x(v) (1) (A), as amended by Pub. L. 96-203, § 223. In issuing such cost limitation regulations, the Secretary is required by statute to utilize a cost determination method which does not shift onto non-Medicare payors the necessary costs of the efficient delivery of services to Medicare-eligible individuals. 42 U.S.C. § 1395x(v) (1) (A) (i). The Secretary is also required to provide a system for making retroactive corrective adjustments for reimbursement of particular providers where the method of determining costs results in inadequate reimbursement. 42 U.S.C. § 1395x(v) (1) (A) (ii).

9. Congress intended the establishment of any cost limits on Medicare reimbursement pursuant to the 1972 Amendments to be for the purposes of curbing excessive costs not necessary in the delivery of health services and of preventing Medicare payments for luxurious accommodations or services. H.R. 92-231, 92d Cong., 2d Sess., May 26, 1971; S.R. No. 92-1230, 92d Cong. 2d Sess., Sept. 26, 1972. Congress also intended that the cost limits would be applied on a presumptive, not a conclusive, basis, and that providers would have an opportunity to demonstrate the reasonableness of their costs in excess of the limits. *Id.*

10. The Medicare routine cost limits regulation, 42 C.F.R. § 405.460, was first issued by the Department in 1974 in response to the 1972 Amendments to the Social Security Act. On June 1, 1979 the Department published amendments to the Medicare cost limits regulation, 42 C.F.R. § 405.460. 44 Fed. Reg. 31802. (The cost limits regulation has been recodified at 42 C.F.R. § 413.30 (1986), 51 Fed. Reg. 34793.)

11. In furtherance of and as an extension of the cost limits regulation, the Department has published schedules of per diem limits on hospital inpatient general routine operating costs. Schedules relevant to this action were issued in "final" by the Department on June 1, 1979, 44 Fed. Reg. 31806; on August 9, 1979, 44 Fed. Reg. 46949; on June 20, 1980, 45 Fed. Reg. 41868; on June 30, 1981, 46 Fed. Reg. 33637; on September 30, 1981, 46 Fed. Reg. 48010; on September 30, 1982, 47 Fed. Reg. 43282, and on August 30, 1983, 48 Fed. Reg. 39426. Other relevant publications of the Department were issuances of proposed schedules, and adjustments to these final schedules.

12. As noted by the Department in the text of each publication of the proposed and final hospital cost limits schedules for the 1979-1983 period, HCFA utilized a wage index prepared by the Bureau of Labor Statistics (BLS) according to HCFA specifications.

13. The employee wage data utilized by BLS as the statistical base to compute the wage indexes were incomplete and inexact because the data were for total wages and total number of employees from an area, without adjustment for full-time or part-time employee status. HCFA has admitted that the data used to compute the BLS wage index is not controlled for variations in full-time equivalency.

14. Failure to adjust this Medicare wage index for full time employee equivalency resulted in a disproportionately low index assigned to states with high part-time employee use.

15. At the time the Department published the hospital cost limits schedule in the 1979-1983 period, it knew or should have known that the wage index was unfair, inequitable, statistically invalid and contrary to law, due to its failure to distinguish between full and part-time employment.

16. No exception is available under the cost limits regulation by which a hospital can have the BLS-computed wage index recalculated to adjust for part-time employee use.

17. In 1984, Congress instructed the Secretary to revise the wage index to reflect the use of part-time employees. Pub. L. 98-369, § 2316(a). The defendant developed a revised wage index based upon actual hospital wage and employment data. 50 Fed. Reg. 24375 (June 10, 1985). This revision substantially raised the wage index in those areas with high proportions of part-time employees. HCFA did not apply the revised wage index retroactively.

18. The hospital cost limits schedule for the 1979-1983 period classified hospital providers as located in either urban or rural areas, based upon whether the location of the provider was inside or outside Standard Metropolitan Statistical Areas ("SMSAs") as defined by the Office of Management and Budget ("OMB"). OMB is not a component part of HHS and OMB has no statutory authority under the Social Security Act to administer the Medicare program. The SMSAs designated by OMB were not determined based upon studies specific to the delivery of health services in the United States generally, nor the delivery of health services by hospital providers under Medicare in particular.

19. The Medicare wage indices for urban hospitals within a given state are uniformly significantly higher than the wage index assigned to all rural hospitals in the same state.

20. According to HCFA regulations and practice, no exception is or has been available under the Medicare cost limits regulation for a hospital located outside an SMSA to be reclassified and reimbursed on a SMSA level, even if the hospital can demonstrate costs comparable to SMSA level hospitals. On this basis, plaintiffs Memorial Community Hospital, Memorial Hospital of Dodge County and Mary Lanning Memorial Hospital were denied requests for such reclassification by HCFA.

21. At the time the Medicare cost limits regulation was amended in 1979 and at the time the hospital inpatient cost limits schedules were issued for the periods 1979-1983, the Department knew or should have known that the SMSA/non-SMSA classifications applied to Medicare reimbursement were unfair, were based on inadequate or inappropriate information or statistical bases, and were contrary to law.

22. To produce the hospital cost limits schedules published during the 1979-1982 period, HCFA and BLS did not use then-current hospital data to create either the labor and non-labor components for the per diem rates or the wage index listings for the rural and SMSA areas. The data base from which averages were calculated was at least two years older than the period to which the resulting cost limits were made applicable.

23. No exception process is available under the cost limits regulation by which plaintiffs can obtain a cost limit adjustment to offset the adverse effects of the Department's reliance on stale employee data.

24. In promulgating the hospital cost limits schedules in 1980 the Secretary improperly sought to achieve overall budgetary controls on Medicare expenditures, rather than to curb hospital costs for reasons authorized under the statute, that is: cost demonstrated to be excessive for the necessary delivery of needed health services, or expended for luxurious items or services.

25. Payment to providers of Medicare services is either made directly or through fiscal intermediaries pursuant to contract with the Secretary. 42 U.S.C. § 1395h. Providers receive periodic interim payments, subject to adjustment for overpayment or underpayment. 42 U.S.C. § 1395g.

After the close of its fiscal year, a provider of services submits a "cost report" reflecting costs incurred during the fiscal year and an apportionment of those costs between Medicare and non-Medicare patients. After audit, the intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit. This final determination is the Notice of Program Reimbursement. 42 C.F.R. § 405.1803. A provider may file an appeal at the Provider Reimbursement Review Board within 180 days of receipt of its NPR to contest any issue relating to its reimbursement. 42 U.S.C. § 1395oo(a).

FACTS RELATING TO PLAINTIFFS

26. During the cost years at issue, each plaintiff had a provider agreement with the Secretary for the provision of Medicare services.

27. During the cost years at issue, the local fiscal intermediary for all of the plaintiff hospitals was Blue Cross of Nebraska under a subcontract with Blue Cross and Blue Shield Association.

28. Each plaintiff filed a timely cost report with the local fiscal intermediary, Blue Cross/Nebraska, for each fiscal year under appeal.

29. Each plaintiff filed a timely request for a hearing before the Board for each cost reporting period under appeal.

30. Plaintiffs Memorial Community Hospital, Memorial Hospital of Seward, and St. Mary's Hospital challenge the application of the rural Nebraska hospital hospital inpatient per diem cost limitation to their claims of costs reimbursable under Medicare in their fiscal years ending in 1980, 1981, 1982, and 1983. Plaintiffs Good Samaritan Hospital and Mary Lanning Memorial Hospital challenge the application of the rural Nebraska per diem

cost limits to their claims of costs reimbursable under Medicare in their fiscal years ending in 1981, 1982 and 1983. Plaintiff Memorial Hospital of Dodge County challenges the application of the rural Nebraska hospital inpatient per diem cost limitation to its claim of costs reimbursable order [sic] Medicare in its fiscal years ending in 1980, 1981, 1982, 1983 and 1984.

31. During the cost years under appeal, the State of Nebraska had one of the nation's highest use of part-time employees in the field of hospital services. The rural Nebraska wage index in the Medicare hospital cost limits schedules during this period was one of the lowest in the nation.

32. The plaintiffs in this case had high levels of part-time employee use during the years under appeal.

33. A study performed by a consultant for the plaintiffs demonstrated that an adjustment factor of 1.1104 (i.e. 11.04%) applied to the rural Nebraska wage index would correct for the adverse effect of the failure of the BLS wage index to account for part-time employees. Significantly, when HCFA developed its own wage index from 1982 hospital data which accounted for the use of part-time employees (see paragraph 17, above), the wage index for rural Nebraska increased by an almost identical 11.25%, from .7411 to .8244.

34. None of the plaintiffs is located in a geographical area which had been designated by OMB as an SMSA during the cost years under appeal. Memorial Hospital of Dodge County is located 6 miles from the Omaha, Nebraska SMSA; Memorial Community Hospital is located 25 miles from the Omaha SMSA; Memorial Hospital, Seward is located 30 miles from the Lincoln, Nebraska SMSA; St. Mary's Hospital is located 50 miles from the Omaha and the Lincoln SMSAs. Good Samaritan is located 124 miles from the Lincoln SMSA;

Mary Lanning Memorial Hospital is located 100 miles from the Lincoln SMSA and 160 miles from the Omaha SMSA.

35. Each of the plaintiffs incurred costs comparable to those of SMSA-located Nebraska hospitals in the period 1979-1983. The four plaintiffs located within 50 miles of an SMSA directly competed with SMSA hospitals to attract staff. Good Samaritan and Mary Lanning Memorial Hospitals had to offer SMSA-level wages to attract staff out to their remote locations.

36. Plaintiff Memorial Community Hospital is located in a county which OMB has determined to be within the Omaha Metropolitan Statistical Area (MSA), based upon the standards for designating MSAs published by OMB in 1980 and upon 1980 census data. OMB announced this determination in January 1983. Memorial Community Hospital requested from HCFA and was refused a retroactive reclassification under 42 C.F.R. § 405.460 to the Omaha urban cost limits per diem level, beginning with its 1980 cost year and covering its 1981, 1982 and 1983 cost years. HCFA and the Secretary have asserted that the Department cannot grant any retroactive reclassification in the Medicare cost limits program because, *inter alia*, the Department has no control over OMB's actions.

37. Rural Nebraska hospitals experienced severe shortages of nursing personnel in their 1978-1980 cost year periods which resulted in reduced wage costs reported on Medicare cost reports.

38. Rural Nebraska wage data from cost reporting periods of 1978-1980 were not equitably or validly adjusted for use in the Medicare hospital cost limits in 1980-82.

39. Each plaintiff was supplied by Blue Cross of Nebraska with a Medicare hospital inpatient rural Nebraska per diem cost limit figure for each fiscal year

under appeal as calculated by Blue Cross/Nebraska according to the Medicare cost limits regulation and cost limits schedule.

40. Each plaintiff either used the per diem cost limit figure supplied by Blue Cross/Nebraska to effect a downward adjustment of this plaintiff's claimed Medicare costs for reimbursement on the cost reports for fiscal years 1980-83, or else Blue Cross/Nebraska inserted the figure in the cost report as audited. HCFA has refused to reimburse the plaintiffs for their reasonable costs in excess of the cost limits.

41. Plaintiff Memorial Hospital of Dodge County significantly altered its accounting methodology beginning with its 1980 fiscal year cost report, in consultation with Blue Cross/Nebraska, to respond to the adverse financial impact of the routine cost limits per diem figure which Blue Cross/Nebraska intended to insert in that plaintiff's 1980 cost report. After this alteration there was still an adverse impact on the cash flow of the hospital.

42. None of the plaintiffs incurred excessive costs or provided luxurious services in offering necessary health services to Medicare beneficiaries during the cost years under appeal. Neither the fiscal intermediary nor the defendant was or is in possession of any studies or evaluations of the plaintiffs showing that any of the plaintiffs either provided necessary health services to Medicare beneficiaries at excessive cost, or provided luxurious services.

43. For each cost year of each plaintiff, the effect of the application of the rural Nebraska per diem cost limitation was to severely and improperly reduce the amount of Medicare reimbursement to less than the statutory standard of reasonable cost properly owed the hospital under the statute. 42 U.S.C. § 1395x(v) (1) (A). The plaintiffs have necessarily had to recoup lost reimbursement

through shifting costs to non-Medicare patients in subsequent cost years.

44. The plaintiffs filed appeals for each of their affected cost years at the Provider Reimbursement Review Board (PRRB or Board). The appeals challenged the validity of the Secretary's cost limits methodology. In particular, the plaintiffs challenged the use of a wage limit methodology which failed to distinguish between full and part-time employees; the use of the SMSA designation as the sole means by which a hospital is classified as an urban hospital without possibility of exception; the use of stale BLS data to construct the wage index applied to any given year, and the conclusive use of the cost limits. In addition, plaintiff Memorial Community Hospital challenged HCFA's refusal to reclassify it as an urban hospital effective with its FY 1980 cost year, when OMB officially designated Memorial Community Hospital's county as part of the Omaha SMSA based on 1980 census data.

45. On June 21, 1988 the plaintiffs filed requests for expedited judicial review with the PRRB, pursuant to 42 U.S.C. § 1395oo(f) (1). The plaintiffs sought a determination by the PRRB that it could not decide the issues under appeal because the PRRB is bound by the Secretary's regulations (including the cost limits schedules) and therefore could not grant the relief the plaintiffs sought.

46. On August 11, 1988 the PRRB granted expedited judicial review for the following plaintiffs and cost years:

Good Samaritan Hospital	FYE 1981, 1982, 1983
Mary Lanning Memorial Hospital	FYE 1980, 1981, 1982, 1983
Memorial Community Hospital	FYE 1980, 1981, 1982, 1983
Memorial Hospital of Dodge County	FYE 1981, 1982, 1983, 1984
Memorial Hospital (Seward)	FYE 1980, 1982, 1983
St. Mary's Hospital	FYE 1980, 1982, 1983

The PRRB letters granting expedited judicial review are attached as Exhibit A.

47. On August 11, 1988 the PRRB issued decisions stating it did not have jurisdiction over the following appeals:

Memorial Hospital Dodge County	FYE 1980
Memorial Hospital (Seward)	FYE 1981
St. Mary's Hospital	FYE 1981

See Exhibit B. The Board found that the hearing requests on the routine cost limits issue for these years were not filed within 180 days after the issuance of the NPR. However, each of these plaintiffs had timely filed a hearing request for the cost year under appeal on another issue. The Medicare regulation at 42 C.F.R. § 405.1841(a) (1) permits a provider, once it has timely filed an appeal for a given cost year, to later add additional issues.

48. Plaintiffs file this complaint within 60 days of the date of the final decisions of the PRRB. This appeal is therefore timely filed.

COUNT I

49. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 48 as if fully set forth herein.

50. The Secretary's promulgation of the costs limits regulation and cost limits schedules was arbitrary, capricious and an abuse of discretion and otherwise not in accordance with law within the meaning of the Administrative Procedure Act, 5 U.S.C. §§ 553 and 706, because of, but not limited to, the following reasons:

(a) the use of a wage index calculated without regard to the effect of the use of part-time or full-time employee data is irrational, inequitable and fails to consider an important aspect of the cost limits system which is the need to use comparable data to prepare estimates;

(b) the principle that hospitals should be classified as rural or urban without possibility of an exception has no rational basis;

(c) the reliance upon data which is known to be outdated is irrational;

(d) the Secretary was on notice from comments filed with HHS, and from data and information provided to or developed within HHS, that the regulation and cost limits schedules were erroneous and unfair. Failure to alter the regulation or schedules was arbitrary, capricious and an abuse of discretion,

(e) the Secretary's decision in setting cost limits was based on inadequate evidence;

(f) the Secretary relied upon factors which Congress did not intend for him to consider.

COUNT II

51. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 50 as if fully set forth herein.

52. The cost limits regulation and hospital cost limits schedules violate the Medicare statute, and specifically 42 U.S.C. § 1395x(v) (1) (A), and therefore are not in accordance with law, because of, but not limited to, the following reasons:

(a) they deny reimbursement for actual costs necessarily incurred in the efficient delivery of health services to Medicare beneficiaries;

(b) they establish estimates of costs which have an inadequate basis in fact, a process which runs contrary to the statutory requirement that the Medicare program reimburse the actual costs of providers;

(c) they establish stringent criteria, not authorized under the statute, concerning geographical locations as an unvarying basis for reimbursing providers;

(d) the regulation does not provide for suitable retroactive corrective adjustments to the cost limits when the costs limits methodology can be shown to rely upon inappropriate and inaccurate wage, geographic, or cost report data;

(e) they cause providers to shift the costs of the care of Medicare patients on to non-Medicare payors;

(f) they are applied on a conclusive rather than a presumptive basis.

COUNT III

53. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 52 as if fully set forth herein.

54. The refusal of the defendant to reclassify Memorial Community Hospital as located within the Omaha SMSA beginning with its 1980 cost year is arbitrary, capricious, an abuse of decision and contrary to law.

55. The defendant's refusal to reclassify Memorial Community Hospital as located within the Omaha urban area is an abrogation of its own responsibility for administering the Medicare Program and an unlawful delegation of authority to OMB.

COUNT IV

56. Plaintiffs restate, reallege and incorporate by reference paragraphs 1 through 55 as if fully set forth herein.

57. The PRRB's decision that it does not have jurisdiction over the appeals of Memorial Hospital of Dodge County (FYE 1980), Memorial Hospital (Seward) (FYE 1980), and St. Mary's Hospital (FYE 1981) with respect to the routine cost limits issue is arbitrary, capricious, an abuse of discretion and contrary to law

because of, but not limited to, the following reasons:

(a) These plaintiffs filed timely hearing requests on other issues for the cost years under appeal;

(b) The regulation at 42 C.F.R. § 405.1841(a) permits providers to add additional issues to an appeal of a given cost year once a hearing request for a cost year has been timely filed.

COUNT V

58. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 57 as if fully set forth herein.

59. Under the Medicare prospective payment system (PPS), for cost reporting periods beginning on or after October 1, 1983, hospitals are paid a predetermined amount per Medicare discharge, depending upon the diagnosis-related group (DRG) into which the patient is classified. 42 U.S.C. § 1395ww(d). For the first four PPS years, a hospital's PPS payment has two components: a hospital-specific portion (termed in the statute the "target" amount) and a federal portion (termed in the statute the "DRG" rate). In the first PPS year, the ratio is 75% hospital-specific/25% federal; in the second year the ratio is 50%/50%; in the third year the ratio is 45%/55%; and in the fourth PPS year, the ratio is 25%/75%. Following the four transition years, hospitals are paid 100% the federal rate. 42 U.S.C. § 1395ww(d) (1) (C).

60. The hospital-specific portion is based upon a hospital's allowable Medicare operating costs in a "base year", i.e., the hospital's cost reporting period ending on or after September 30, 1982. 42 U.S.C. § 1395ww(d) (1) (A) (i) (I), incorporating § 1395ww(b) (3) (A). Each of the plaintiffs has its PPS base year as one of the years under appeal in this case.

61. The Medicare statute defines the "target amount"

as "the allowable operating costs of inpatient hospital services" in the base year. 42 U.S.C. § 1395ww(d) (1) (A) (i) (I), incorporating subsection (b) (3) (A). If a hospital's allowable operating costs for the base year are increased for any reason, including as a result of a base year appeal, the hospital-specific rate for all PPS years should therefore be adjusted to reflect the additional allowable base year costs. Thus, if this court rules in plaintiffs' favor on Counts I, II and III of this Complaint, the hospital-specific rates for all of the plaintiffs' PPS years should be automatically adjusted to reflect the increase in allowable base year costs.

62. The Secretary's regulations prohibit automatic retroactive adjustments to hospital-specific rates, to reflect additional allowable base year costs. 42 C.F.R. § 412.72(a) (3)(ii). Instead, the Secretary's regulations provide that the hospital-specific rate will be retroactively adjusted only if the intermediary failed to use the "best data available" at the time it calculated the hospital-specific rate, and if "the estimation [of base year costs] was unreasonable and clearly erroneous in light of the data available at the time the estimation was made." 42 C.F.R. § 412.72(b) (2). The regulations further exclude from administrative and judicial review "any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation." 42 C.F.R. § 412.72(b) (3). These regulations are contrary to the statute which requires that *all* allowable base year costs be reflected in the hospital-specific rates for all PPS years.

63. The Secretary has already indicated he will not make a retroactive adjustment to the hospital-specific rates to include additional base year costs recognized as a result of the invalidation of a Medicare regulation or policy. *See e.g.*, 53 Fed. Reg. 22031 (June 13, 1988) ("If a [base year] disallowance was based on a legal interpreta-

tion later held incorrect by the courts, the validity of the [hospital-specific] rates would not be affected if the intermediary made a good faith attempt to act in accordance with the law and regulations as they were understood when the rates were established.") Thus, the result under the Secretary's regulations is that the hospital-specific rates for PPS years will continue to be calculated under an invalidated regulation or policy. This result is (1) contrary to the Medicare statute which requires that the hospital-specific rate be based on all allowable base year operating costs; and (2) inconsistent with the regulation at 42 C.F.R. § 412.72(a) (3) (ii) which requires an automatic adjustment to the hospital-specific rate of PPS years beginning after the date a hospital wins its base year appeal. Hence this result is contrary to law.

WHEREFORE, the plaintiffs pray judgment against the defendant as follows:

1. For a declaration that the action of the Secretary in promulgating and applying the cost limits regulation and the hospital cost limits schedules was arbitrary, capricious, an abuse of discretion and not in accordance with law as to:

A. the use of a wage index based on data which does not take into account the degree and effect of part-time employee use;

B. the unvarying classification of providers as urban or rural based upon OMB definitions;

C. the use of stale data inadequately updated as the basis for a cost limitation of a hospital's actual costs in subsequent cost years;

D. the conclusive use of the cost limits to deny reimbursement of reasonable costs.

2. For an order declaring that the cost limits schedules effective from June 1, 1979 through September 30, 1983 were illegal on their face and/or as applied in this case.

3. For an order requiring the Secretary to apply a wage index which takes into account the high use of part-time employees by hospitals in Nebraska to the cost years under appeal.

4. For an order requiring the Secretary to reimburse plaintiff hospitals according to the urban cost limits applicable to the nearest SMSA for the cost years under appeal.

5. For an order requiring the Secretary to reimburse plaintiff hospitals for their reasonable costs for the years under appeal without regard to the cost limits.

6. For a declaration that the Secretary's failure to reclassify Memorial Community Hospital as within the Omaha urban area as of 1980 is arbitrary, capricious and not in accordance with law, and for an order that the plaintiff shall be so reclassified and shall be reimbursed according to the cost limits applicable to the Omaha SMSA for the cost years under appeal.

7. For a declaration that the PRRB has jurisdiction over the appeals of Memorial Hospital of Dodge County (FY 1980), Memorial Hospital (Seward) (FY 1981), and St. Mary's Hospital (FY 1981).

8. For an order of this court directing the Secretary to adjust plaintiffs' hospital-specific rates for all PPS transition years to reflect additional allowable base year costs recognized as a result of this appeal, and to make payment accordingly, with interest.

9. For an order awarding plaintiffs their costs and interest in accordance with 42 U.S.C. §§ 1395oo(f) 1395x(v) (1) (B), at the rate of one times the rate of interest payable on obligations of the Federal Hospital Insurance Trust Fund in effect at the time this civil action was filed, for this action.

10. For such other relief as this Court deems just and appropriate.

Respectfully submitted,

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(Certificate of Service omitted in printing.)

[Exhibit A reprinted in Pet. App. 37a-54a]

(Exhibit B omitted in printing.)

UNITED STATES DISTRICT COURT
DISTRICT OF NEBRASKA

Civil Action No. 88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

ANSWER TO AMENDED COMPLAINT

Defendant, Otis R. Bowen, M.D., Secretary of Health and Human Services, answers the Amended Complaint as follows:

FIRST DEFENSE

Plaintiffs have failed to state a claim upon which relief can be granted.

SECOND DEFENSE

This Court lacks jurisdiction over (1) the claim by Memorial Hospital (Seward) for its fiscal year ending September 30, 1981, (2) the claim by Memorial Hospital of Dodge County for its fiscal year ending December 31, 1980, and (3) the claim by St. Mary's Hospital for its fiscal year ending September 30, 1981.

THIRD DEFENSE

Defendant answers the numbered paragraphs of the Amended Complaint as follows:

1. Admits.
2. Admits.
3. Denies, except to aver that this action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*
4. Admits, except to deny that this Court has jurisdiction over (1) the claim by Memorial Hospital (Seward) for its fiscal year ending September 30, 1980, (2) the claim by Memorial Hospital of Dodge City for its fiscal year ending December 31, 1980, and (3) the claim by St. Mary's Hospital for its fiscal year ending September 30, 1981.
5. Admits.
6. Admits.

7-9. Paragraphs 7, 8 and 9 purport to quote and characterize the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, as such these paragraphs constitute conclusions of law and not allegations of fact to which an answer is required. Insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately quote the Act. Defendant respectfully refers the court to the cited provisions of the Social Security Act, 42 U.S.C. §§ 1395cc, 1395f(b)(1)(A), 1395x(v)(1)(A), and the cited House and Senate Reports for an accurate and complete statement of their contents.

10. Admits.
11. Admits.
12. Admits.
13. The first sentence of paragraph 13 sets forth plaintiffs' characterization of wage indices and data utilized by the Health Care Financing Administration ("HCFA") to which no answer is required. Insofar as an answer may be deemed to be required, defendant denies the allegations in the first sentence, except to admit that the data was not adjusted for part-time employee status. Defendant admits the allegations in the last sentence but avers that the data

used to compute the BLS wage index was the best data available at the time.

14. Defendant admits the wage index for states with a high part-time employee use may have been low because the wage index was not adjusted for full time employee equivalency.
15. Denies.
16. Admits.
17. Admits.
18. Admits.
19. Denies.
20. Defendant denies the allegations in the first sentence, and defendant respectfully refers the court to the regulations, particularly 42 C.F.R. 405.460, for an accurate and complete statement of the applicable cost limit exceptions. Defendant admits that Memorial Community Hospital was denied its request for reclassification by HCFA, but defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations as to the other hospitals.
21. Paragraph 21 contains conclusions of law and not allegations of facts to which an answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in paragraph 21.
22. Defendant admits that the data used to create the labor and non-labor components for the per diem rates or wage index listing was based on costs for previous years, but defendant avers that the data was the most recent data available.
23. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in this paragraph. Defendant, however, refers the court to 42 C.F.R. § 405.460 for an accurate and complete statement of the exceptions available to providers.

24. Paragraph 24 contains conclusions of law and not allegations of fact to which an answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations.

25. Defendant admits the allegations in the first three sentences and the last two sentences. Defendant denies the allegations in the fourth sentence, but avers that the intermediary issues a final determination of the amount payable under the Medicare Program based on the cost report and audit, if an audit is performed.

26. Admits.

27. Admits.

28. Admits.

29. Denies.

30. Admits.

31. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence. Defendant admits the allegations in the last sentence.

32. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 32.

33. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence of paragraph 33. The second sentence sets forth plaintiffs' characterization of the HCFA wage indices to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the wage indices. Defendant refers the court to the revised wage index for an accurate and complete statement of its terms.

34. Admits.

35. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 35.

36. Defendants admits the allegations in the first two sentences. The last sentence sets forth plaintiffs' characterization of HCFA's decision on Memorial Community Hospital's request for retroactive reclassification to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the decision. Defendant refers the court to the Department's decision for an accurate and complete statement of its reasons.

37. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 37.

38. Paragraph 38 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 38.

39. Admits.

40. Defendant admits the allegations in the first sentence of paragraph 40. The second sentence contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies.

41. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraph 41.

42. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the first sentence of paragraph 42. Defendant admits the allegations in the second sentence of paragraph 42.

43. The first sentence of paragraph 42 [sic] contains conclusions of law to which no answer is required, but insofar an answer may be deemed to be required defendant denies the allegations. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations set forth in the second sentence.

44. Admits.

45. Admits.

46. Admits, except to deny that the Provider Reimbursement Review Board granted expedited review to Mary Lanning Memorial Hospital for its fiscal year 1980.

47. Defendant admits the allegations in the first two sentences. The last two sentences contain plaintiffs' conclusions of law to which no response is required; insofar as an answer may be deemed to be required, defendant denies.

48. Admits.

49. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 48.

50. Paragraph 50 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 50.

51. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 50.

52. Paragraph 52 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 52.

53. Defendant reiterates and incorporates by reference his answers to paragraph 1 through 52.

54-55. Paragraphs 54 and 55 contain plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be required, defendant denies paragraphs 54 and 55.

56. Defendant reiterates and incorporates his answers to paragraphs 1 through 55.

57. Paragraph 57 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies paragraph 57.

58. Defendant reiterates and incorporates his answers to paragraphs 1 through 57.

59. Paragraph 59 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this paragraph constitutes conclusions of law and not allegations of fact to which an answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. §§ 1395ww(d) for an accurate and complete statement of its terms.

60. The first sentence of paragraph 60 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this sentence constitutes conclusions of law and not allegations of fact to which an response is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. §§ 1395ww(d)(1)(A)(i)(I) and 1395ww(b)(3)(A) for an accurate and complete statement of their terms. Defendant admits allegations in the last sentence.

61. The first sentence of paragraph 61 sets forth plaintiffs' characterizations of certain provisions of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, as such this sentence constitutes conclusions of law and not allegations of fact to which an answer is required; insofar as an answer may be required, defendant denies, except to the extent they accurately reflect the statute. Defendant respectfully refers the court to 42 U.S.C. § 1395(d)(1)(A)(i)(I) for an accurate and complete statement of its terms. The last sentence of paragraph 61 contains conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations.

62. The first three sentences of paragraph 62 set forth plaintiffs' characterizations of certain regulations to which no answer is required; insofar as answer may be deemed to be required, defendant denies, except to the extent they accurately reflect the regulations. Defendant respectfully refers the Court to 42 C.F.R. §§ 412.72(a)(3)(ii), 412.72(b)(2), and 412.72(b)(3) for an accurate and complete statement of their terms. The last sentence in paragraph 62 contains plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in this sentence.

63. The first sentence in paragraph 63 sets forth plaintiffs' characterization of a Federal Register Notice issued by the defendant to which no answer is required; insofar as an answer may be deemed to be required, defendant denies, except to the extent it accurately reflects the notice. Defendant respectfully refers the court to the notice for an accurate and complete statement of its terms. The remaining sentences in paragraph 63 contain plaintiffs' conclusions of law to which no answer is required, but insofar as an answer may be deemed to be required, defendant denies the allegations in these sentences.

Defendant hereby specifically denies all of the allegations of the complaint not hereinbefore otherwise answered.

WHEREFORE, defendant request that this Amended Complaint be dismissed and the defendant awarded costs and be granted such other relief to which it may be entitled.

Respectfully submitted,

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(Certificate of Service omitted in printing.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV88-L-523

GOOD SAMARITAN HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF
HEALTH AND HUMAN SERVICES, DEFENDANT.

[FILED FEB. 16, 1990]

JUDGMENT

In accordance with today's memorandum on the plaintiff's and defendant's cross-motions for summary judgment,

IT IS ORDERED that:

1. judgment is entered for the plaintiffs on the issue of corrective adjustments to cost limit rules;
2. judgment is entered for the defendant on all other issues.

The case is remanded to the Secretary for a hearing from which he (1) shall apply to the cost years under appeal a wage index that takes into account the high use of part-time employees by hospitals in Nebraska and (2) shall consider the non-SMSA designation of the plaintiffs in determining whether the aggregate reimbursement pro-

duced by the methods of determining costs has proved to be adequate.

Dated February 16, 1990.

BY THE COURT
/s/ [SIGNATURE ILLEGIBLE]
United States District Judge